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Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities—Update; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 411, 413, and 489

[HCFA–1112–F]

RIN 0938–AJ93

Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities—Update

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Final rule.

SUMMARY: This final rule sets forth updates to the payment rates used under the prospective payment system (PPS) for skilled nursing facilities (SNFs), for fiscal year 2001. Annual updates to the PPS rates are required by section 1888(e) of the Social Security Act, as amended by the Medicare, Medicaid and State Child Health Insurance Program Balanced Budget Refinement Act of 1999, related to Medicare payments and consolidated billing for SNFs. In addition, this rule sets forth certain conforming revisions to the regulations that are necessary in order to implement amendments made to the Act by section 103 of the Medicare, Medicaid and State Child Health Insurance Program Balanced Budget Refinement Act of 1999.

EFFECTIVE DATE: These regulations are effective on October 1, 2000.

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In addition, because of the many terms to which we refer by abbreviation in this rule, we are listing these abbreviations and their corresponding terms in alphabetical order below:

ADL Activity of Daily Living
BBA Balanced Budget Act of 1997, P.L. 105–33
BBRA Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999, P.L. 106–113, Appendix F
BLS (U.S.) Bureau of Labor Statistics
CPI Consumer Price Index
HCFA Health Care Financing Administration
HCPCS HCFA Common Procedure Coding System
IFC Interim Final Rule with Comments
MDS Minimum Data Set
MSA Metropolitan Statistical Area
PPI Producer Price Index
PPS Prospective Payment System
PRM Provider Reimbursement Manual
RUG–III Resource Utilization Groups, version III
SCHIP State Child Health Insurance Program
SNF Skilled Nursing Facility

I. Background

On April 10, 2000, we published in the **Federal Register** (65 FR 19188), a proposed rule that set forth updates to the payment rates used under the prospective payment system (PPS) for skilled nursing facilities (SNFs), for fiscal year (FY) 2001. Furthermore, it specifically proposed changes to the SNF PPS case-mix methodology. Annual updates to the PPS rates are required by section 1888(e) of the Social Security Act (the Act), as amended by the Medicare, Medicaid and State Child Health Insurance Program Balanced Budget Refinement Act of 1999, related to Medicare payments and consolidated billing for SNFs. In addition, the rule proposed certain conforming revisions to the regulations necessary in order to implement amendments made to the Act by section 103 of the Medicare, Medicaid and State Child Health Insurance Program Balanced Budget Refinement Act of 1999 (BBRA), Public Law 106–113, Appendix F.

A. Current System for Payment of Skilled Nursing Facility Services Under Part A of the Medicare Program

Section 4432 of the Balanced Budget Act of 1997 (BBA) (Public Law 105–33) mandated the implementation of a per diem PPS for SNFs, covering all costs (routine, ancillary, and capital) of covered SNF services furnished to beneficiaries under Part A of the Medicare program, effective for cost reporting periods beginning on or after July 1, 1998. We are updating the per

diem payment rates for SNFs, for FY 2001. Major elements of the SNF PPS include:

• *Rates*: Per diem Federal rates were established for urban and rural areas using allowable costs from FY 1995 cost reports. These rates also included an estimate of the cost of services that, before July 1, 1998, had been paid under Part B but furnished to Medicare beneficiaries in a SNF during a Part A covered stay. Rates are case-mix adjusted using a classification system (Resource Utilization Groups, version III (RUG–III)) based on beneficiary assessments (using the Minimum Data Set (MDS) 2.0). In addition, the Federal rates are adjusted by the hospital wage index to account for geographic variation in wages. Further, the rates are adjusted annually using an SNF market basket index.

• *Transition*: The SNF PPS includes a 3-year, phased transition that blends a facility-specific payment rate with the Federal case-mix adjusted rate. For each cost reporting period after a facility migrates to the new system, the facility-specific portion of the blend decreases and the Federal portion increases, in 25 percent increments. For most facilities, the facility-specific rate is based on allowable costs from FY 1995. As discussed later in this final rule, section 102 of the BBRA authorized facilities to elect to bypass the transition to be paid at the full Federal rate.

• *Coverage*: The PPS statute did not change Medicare's fundamental requirements for SNF coverage. However, because RUG–III classification is based, in part, on the beneficiary's need for skilled nursing care and therapy, we have attempted where possible to coordinate claims review procedures with the outputs of beneficiary assessment and RUG–III classifying activities.

• *Consolidated Billing*: The statute includes a billing provision that requires a SNF to submit consolidated Medicare bills for its beneficiaries for virtually all services that are covered under either Part A or Part B. The statute excludes a small list of services (primarily those of physicians and certain other types of practitioners). As discussed later in this final rule, section 103 of the BBRA has identified certain additional services for exclusion, effective April 1, 2000.

B. Requirements of the Balanced Budget Act of 1997 for Updating the Prospective Payment System for Skilled Nursing Facilities

Section 1888(e)(4)(H) of the Act requires that we publish in the **Federal Register:**

1. The unadjusted Federal per diem rates to be applied to days of covered SNF services furnished during the FY.

2. The case-mix classification system to be applied with respect to these services during the FY.

3. The factors to be applied in making the area wage adjustment with respect to these services.

In addition, in the July 30, 1999 final rule (64 FR 41670), we indicated that we would announce any changes to the guidelines for Medicare level of care determinations related to Part A SNF services or to the RUG–III classifications.

Along with a number of other revisions and refinements discussed later in this preamble, this final rule provides the annual updates to the Federal rates, as mandated by the Medicare statute.

C. The Medicare, Medicaid and State Child Health Insurance Program (SCHIP) Balanced Budget Refinement Act of 1999 (BBRA)

As a result of enactment of the BBRA, there are several new provisions that result in adjustments to the PPS for SNFs. The following provisions were described in the proposed rule that we published on April 10, 2000 (65 FR 19188), and are discussed further in section III. of this preamble, to the extent that we received public comments concerning them:

• Section 101 provides for a temporary, 20 percent increase in the per diem adjusted payment rates for 15 specified RUG–III groups (SE3, SE2, SE1, SSC, SSB, SSA, CC2, CC1, CB2, CB1, CA2, CA1, RHC, RMC, and RMB). This legislation provides that the 20 percent increase takes effect with SNF services that are furnished on or after April 1, 2000, and continues until the later of October 1, 2000, or implementation by the Secretary of a refined RUG system. Thus, the 20 percent increase serves as a temporary, interim adjustment to the payment rates and RUG–III classification system as published in the final rule of July 30, 1999, and will continue until implementation of the case-mix refinements described in the legislation. As discussed in Section III., we are not implementing such case-mix refinements in this final rule. Therefore, the 20 percent increase for the specified RUG–III groups will remain in effect during FY 2001. Section 101 also includes an across-the-board increase in the adjusted Federal per diem payment rates by 4 percent each year for FYs 2001 and 2002, exclusive of the 20 percent increase.

• Section 102 authorizes SNFs that would otherwise be subject to the three-year, phased transition from facility-specific to Federal rates to elect instead to make an immediate transition to the full Federal rate.

• Effective April 1, 2000, section 103 excludes from the SNF PPS bundle and the consolidated billing requirement certain types of ambulance services, certain customized prosthetic devices, and certain services involving chemotherapy and its administration; beginning with FY 2001, this section also requires a corresponding proportional reduction in Part A SNF payments.

• Section 104 provides for a Part B add-on for facilities participating in the Multistate Nursing Home Case-Mix and Quality (NHCMQ) Demonstration Project.

• Section 105 provides for a 50 percent Federal, 50 percent facility-specific payment rate for those SNFs that serve certain specialized patient populations.

• Section 155 provides that PPS payment to certain SNF providers located in Baldwin or Mobile County, Alabama, are based on 100 percent of their facility specific rates for cost reporting periods that begin in FY 2000 or FY 2001.

We included further information on these provisions in Program Memorandums A–99–53 and A–99–61 (December 1999), and Program Memorandum A–00–18 (March 2000).

D. Skilled Nursing Facility Prospective Payment—General Overview

The Medicare SNF PPS was implemented for cost reporting periods beginning on or after July 1, 1998. Under the PPS, SNFs are paid through prospective, case-mix adjusted per diem payment rates applicable to all covered SNF services. These payment rates cover all the costs of furnishing covered skilled nursing services (that is, routine, ancillary, and capital-related costs) other than costs associated with approved educational activities. Covered SNF services include posthospital SNF services for which benefits are provided under Part A and all items and services that, before July 1, 1998, had been paid under Part B (other than physician and certain other services specifically excluded under the BBA) but furnished to Medicare beneficiaries in a SNF during a Part A covered stay. (A complete discussion of these provisions appears in the May 12, 1998 interim final rule (63 FR 26252)).

1. Payment Provisions—Federal Rate

The statute sets forth a fairly prescriptive methodology for calculating the amount of payment under the SNF PPS. The PPS utilizes per diem Federal payment rates based on mean SNF costs in a base year updated for inflation to the first effective period of the PPS. We developed the Federal payment rates using allowable costs from hospital-based and freestanding SNF cost reports for reporting periods beginning in FY 1995. The data used in developing the Federal rates also incorporate an estimate of the amounts that would be payable under Part B for covered SNF services to individuals who were receiving Part A covered services in an SNF.

In developing the rates for the initial period, we updated costs to the first effective year of PPS (15-month period beginning July 1, 1998) using a SNF market basket index, and standardized for facility differences in case-mix and for geographic variations in wages. Providers that received ''new provider'' exemptions from the routine cost limits were excluded from the database used to compute the Federal payment rates. In addition, costs related to payments for exceptions to the routine cost limits were excluded from the database used to compute the Federal rates. In accordance with the formula prescribed in the BBA, we set the Federal rates at a level equal to the weighted mean of freestanding costs plus 50 percent of the difference between the freestanding mean and weighted mean of all SNF costs (hospital-based and freestanding) combined. We compute and apply separately the payment rates for facilities located in urban and rural areas. In addition, we adjust the portion of the Federal rate attributable to wage related costs by a wage index.

The Federal rate also incorporates adjustments to account for facility case-mix using a classification system that accounts for the relative resource utilization of different patient types. This classification system, RUG–III, utilizes beneficiary assessment data (from the Minimum Data Set or MDS) completed by SNFs to assign beneficiaries into one of 44 groups. The May 12, 1998 interim final rule (63 FR 26252) has a complete and detailed description of the RUG–III classification system. The BBA requires us to publish the SNF PPS case-mix classification methodology applicable for the next Federal FY before August 1 of each year. In the proposed rule, we discussed options for refining the existing RUG–III classification system. Further discussion of this issue appears in Section III. A. of this rule.

The Federal rates reflected in this rule update the rates in the July 30, 1999 update notice (64 FR 41684) by a factor equal to the SNF market basket index minus 1 percentage point. According to section 1888(e)(4)(E)(ii) of the Act, for FYs 2001 and 2002, we will update the rate by adjusting the current rates by the SNF market basket change minus 1 percentage point. For subsequent FYs, we will adjust the rates by the applicable SNF market basket change.

2. Payment Provisions—Transition Period

Beginning with a provider's first cost reporting period beginning on or after July 1, 1998, there is a transition period covering three cost reporting periods. During the transition period, SNFs receive a payment rate comprising a blend between the Federal rate and a facility-specific rate based on each facility's FY 1995 cost report. Under section 1888(e)(2)(E)(ii) of the Act, SNFs that received their first payment from Medicare on or after October 1, 1995 receive payment according to the Federal rates only.

For SNFs subject to transition, the composition of the blended rate varies depending on the year of transition. For the first cost reporting period beginning on or after July 1, 1998, we make payment based on 75 percent of the facility-specific rate and 25 percent of the Federal rate. In the next cost reporting period, the rate consists of 50 percent of the facility-specific rate and 50 percent of the Federal rate. In the following cost reporting period, the rate consists of 25 percent of the facility-specific rate and 75 percent of the Federal rate. For all subsequent cost reporting periods, we base payments entirely on the Federal rates.

As noted elsewhere in this regulation, in accordance with section 102 of the BBRA, SNFs that would otherwise be subject to the statutory three-year, phased transition from facility-specific to Federal rates, may elect to bypass the transition and go directly to the full Federal rate. This amendment applies to elections made on or after December 15, 1999, except that no election will be effective for a cost reporting period beginning before January 1, 2000; an election is effective for a cost reporting period beginning no earlier than 30 days before the date of the election.

3. Payment Provisions—Facility-Specific Rate

For most facilities, we compute the facility-specific payment rate utilized for the transition using the allowable costs of SNF services for cost reporting periods beginning in FY 1995 (cost reporting periods beginning on or after October 1, 1994 and before October 1, 1995). Included in the facility-specific per diem rate is an estimate of the amount that would be payable under Part B for covered SNF services furnished during FY 1995 to those beneficiaries in the facility who were receiving Part A covered services. The facility-specific rate, in contrast to the Federal rates, includes amounts paid to SNFs for exceptions to the routine cost limits. In addition, we also take into account ''new provider'' exemptions from the routine cost limits, but only to the extent that routine costs do not exceed 150 percent of the routine cost limit.

We update the facility-specific rate for each cost reporting period after 1995 by a factor equal to the SNF market basket percentage increase minus 1 percentage point. In each subsequent year, we will update it by the applicable SNF market basket increase.

II. Provisions of the Proposed Rule

The proposed rule that we published in the **Federal Register** (65 FR 19188, April 10, 2000) included proposed FY 2001 updates to the Federal payment rates used under the SNF PPS. In accordance with section 1888(e)(4)(E)(ii)(II) of the Act, the proposed updates reflected the SNF market basket percentage change for that fiscal year minus 1 percentage point. Also, in order to facilitate the incorporation of proposed refinements into the case-mix classification system (see discussion in Section III. A. of this final rule), we created a separate component of the payment rates specifically to account for non-therapy ancillary costs (which have been included within the overall nursing case-mix component of the payment rates). In addition, the proposed rule described our methodology for adjusting the Federal rates in accordance with section 103 of the BBRA, in order to reflect that provision's exclusion of certain additional items and services from the SNF PPS and consolidated billing. Further, we provided for a 4 percent increase in the adjusted Federal rate, in accordance with section 101 of the BBRA. We also included a discussion of the rights of SNFs to appeal their payment rates under the PPS (65 FR 19192). In addition, we proposed to make certain refinements in the case-mix classification system, in accordance with section 101 of the BBRA (see discussion in Section III. A. of this final rule).

In addition to discussing these general issues in the proposed rule, we also proposed to make the following specific revisions to the existing text of the regulations:

- In § 411.15, paragraph (p)(2)(vii) would be revised to exclude from consolidated billing those ambulance services that are furnished to an SNF resident in conjunction with dialysis services that are covered under Part B.
- In § 411.15, paragraph (p)(2) would also be revised to list the additional services that section 103 of the BBRA has excluded from consolidated billing.
- In § 411.15, paragraph (p)(3)(iv), the phrase ''within 24 consecutive hours'' would be revised to read ''by midnight of the day of departure''.
- In § 489.20, paragraph (s) would be revised to list the additional services that the BBRA has excluded from consolidated billing, and a conforming change would be made in § 489.21(h).
- In § 489.20, paragraph (s)(7) would be revised to exclude from consolidated billing those ambulance services that are furnished to an SNF resident in conjunction with dialysis services that are covered under Part B.
- Section 489.20(s)(11) and § 411.15(p)(2)(xi), would be revised to reflect editorial revisions in the paragraphs concerning the transportation costs of electrocardiogram equipment.

More detailed information on each of these issues can be found in the discussion contained in the following section of this final rule.

III. Analysis of and Responses to Public Comments

In response to the publication of the proposed rule on April 10, 2000, we received approximately 750 comments. The majority consisted of form letters, in which we received multiple copies of an identically-worded letter that had been signed and submitted by different individuals. Furthermore, we received over 30 comments from various trade associations and other major organizations. Comments originated from nursing homes and other providers, suppliers and practitioners (both individually, and through their respective trade associations), nursing home resident advocacy groups, health care consulting firms, and private citizens. While the comments fell into several broad areas, by far the largest number involved the refinements that we proposed to make in the PPS case-mix classification system, in accordance with section 101 of the BBRA.

A. Case-Mix Refinements

The proposed rule discussed options for refinements to the RUG-III system, described ongoing research and analyses, shared the initial results that we proposed be incorporated into the Medicare PPS system effective October 1, 2000, and solicited comments from all interested parties.

1. Potential Case-Mix Refinements Described in the Proposed Rule

Comment: We received numerous comments on the potential refinements, the supporting data, and the analyses planned to validate the data. Commenters were concerned first about our ability to complete the analyses on a timely basis, and then on how we would use the additional analyses in setting the FY 2001 rates. They also expressed concerns that the proposed refinements might not adequately address the problems that they perceived with current PPS payment levels.

Response: In the proposed rule (65 FR 19202), we indicated that we believed our preliminary research findings to be valid, but we also noted that

> * * * it is certainly possible that additional testing will identify new issues or suggest alternative refinements to those presented here. We remain open to suggestions during the comment period and will carefully evaluate the validation analyses before proceeding to final rulemaking.

We conducted the validation analyses discussed in the proposed rule to identify the actual distribution of the Medicare population, to determine any cost or acuity differences associated with short stay beneficiaries, and to validate the predictive power of the unweighted and weighted models in identifying variations in ancillary costs using national data from a current period (for example, after the implementation of the SNF PPS). We identified several important variations in the volume and distribution of beneficiaries and ancillary services costs using the 1999 national data which appear to have affected the performance of the index models described in the proposed rule.

In examining the 1999 data, it is apparent that the introduction of the PPS and consolidated billing provisions for covered Part A SNF stays has caused changes in facility practice patterns and billing, although some of this change may be the effect of using national data. In part, these variations may be related to changes in facility practices regarding the use of pharmaceuticals and in the way respiratory therapy services are provided to Medicare beneficiaries. For example, respiratory therapy (RT) was a significant portion of the non-therapy ancillary services in the pre-PPS data base used to develop the refinement models. This component of cost provided a significant contribution to the predictive power of the index models presented in the proposed rule. However, mean RT costs decreased from $16.04 based on a re-analysis of the six State sample to $5.46 in the 1999 national data base (or a 66 percent decrease). We believe that the decrease may be a result of both more prudent use of the services (RT has been a target of OIG studies in utilization and pricing) and the incentives created by the PPS (for example, the use of nurses to provide RT care). On the other hand, average drug costs increased from $29.93 based on a re-analysis of the six State sample to $92.38 in 1999 national data base. Therefore, when applying the non-therapy ancillary index indicators to the national PPS data, we found the models were less effective in predicting ancillary cost variations than when applied to the earlier research data.

As stated in the proposed rule, we were committed to validating the research results before proceeding to a refinement which required such a large expansion of the RUG–III classification system and impact on the delivery of SNF care. Since our latest validation analyses do not confirm the effectiveness of index models in the current PPS environment, we are not proceeding with implementation of the RUG refinements discussed in the proposed rule. Therefore, for FY 2001, we will be maintaining the existing 44-group RUG–III configuration. Consequently, we will also maintain the 20 percent add-on to the Federal rates for the 15 selected RUG-III groups, in accordance with section 101 of BBRA.

The inability to validate the specific non-therapy ancillary index models described in the proposed rule does not preclude us from further efforts to improve the payment system's ability to allocate payments based on expected ancillary use. However, additional research will be needed to identify variables that will be effective predictors in the PPS environment. Now that we have developed a large national database of claims and MDS records from 1999, we plan to continue research on the development of a non-therapy ancillary index, as well as to investigate other potential refinement approaches. In continuing this research, we will carefully consider the comments we received, and use these comments to assist us in exploring potential solutions.

Finally, as indicated in the April 10, 2000, proposed rule, both non-therapy ancillary index models were designed in conjunction with an addition to the RUG–III hierarchy; for example, 14 combined Extensive Services/ Rehabilitation groups. While this approach may warrant further exploration, we are not adopting it at this time. The validation analyses looked at the impact of both components of the proposed refinements: the expansion of the RUG–III groups and the creation of a non-therapy ancillary index. The combined predictive power of both components was approximately 3 percent. Measured separately, the added predictive power of either component would be negligible. The benefit of expanding the number of RUG–III groups would be too small to justify the added complexity of the RUG–III system. We will continue to work to develop ways to address the needs of those beneficiaries who require an unusually heavy combination of clinical care, rehabilitation services, and ancillary utilization, without creating perverse incentives that could negatively affect the quality of care for this vulnerable segment of the beneficiary population.

2. Clinical Issues

Comment: One commenter raised an issue involving certain restrictions placed by SNF administrators on staff's provision of therapies. The commenter reported that SNFs frequently constrain the amount of therapy therapists are permitted to provide the beneficiaries in particular facilities. Specifically, the commenter stated that therapists have been instructed by SNFs to limit therapy minutes to the minimum required for the medium RUG–III groups.

Response: In view of this comment, in addition to other anecdotal evidence, we believe it is appropriate to reiterate some key points of Medicare policy. As we previously stated in the final rule of July 30, 1999 (64 FR 41662), the number of minutes per week that are used as qualifiers for classification into the rehabilitation RUG–III groups ''are minimums and are not to be used as upper limits for service provision.'' Facilities with patterns of therapy service provided at the minimum levels may be targeted for medical review and other audit activities. Arbitrary decisions by facility administrative staff to override the professional decision-making regarding which types and how much therapy service are needed by, and will be provided to, the individual beneficiary are inconsistent with our requirements for individual evaluations by a licensed professional therapist, care plan development that involves the physician and the professional therapist, and the strict rules we have promulgated regarding supervision of therapy service provision when service is provided by someone other than the licensed professional.

Further, the Medicare requirements for participation (at section 1819(b) of the Act) require SNFs to provide the services necessary to attain each resident's highest level of physical functioning. Any facility level policy that obstructs this goal is in direct conflict with Medicare policy.

In addition, because we are not implementing the RUG–III refinements as proposed, we are concerned about some of the payment incentives associated with the 20 percent add-ons for 15 of the RUG–III groups. We are especially concerned about the effect on provider behavior that could result from the incentive provided by the add-on for such groups as those in the extensive services category, and for three of the rehabilitation RUG–III groups. For example, the additional payment for the RHC, RMC, and RMB groups results in higher payment for these groups than for some other, higher-level rehabilitation groups. We want to make clear that although this may create a fiscal incentive to provide less service in order to receive a higher rate of payment, we expect that facilities will continue to provide therapy at the levels most appropriate for each individual beneficiary.

However, we realize that this is a powerful incentive and, therefore, are working on ways to monitor the inappropriate denial of services to beneficiaries in facilities' attempts to achieve higher payment. We are exploring our monitoring options and strategies to detect and deter inappropriate practices in this area, and will be able to present more specific information about our plans at our fall fiscal intermediary and provider training sessions. Monitoring activities will include our use of MDS data linked to SNF bills (which allows us to identify patterns and trends of SNF use and RUG–III group distributions), the SNF PPS Quality Medical Review Pilot and Data Analysis Peer Review Organization (which will specifically focus on the impact of the PPS in terms of quality of care and the potential for underutilization), and survey reports. At the facility level, we would certainly expect that any significant shift in beneficiary RUG–III classifications (for example, all beneficiaries being classified into the rehabilitation groups that have the 20 percent add-on), would result in closer monitoring and possible intervention.

Comment: We received a few comments regarding the clinical items used as indicators for the non-therapy ancillary index. The commenters suggested additional MDS items that they believe should be used to trigger additional payment.

Response: The clinical items used as indicators for the non-therapy ancillary indices, in the models discussed in the proposed rule are based on the data analyses performed to create the models. We did not undertake the research with any preconceived expectations or preferences as to the variables we believed would be most predictive of non-therapy ancillary cost. Rather, we looked to the data itself to identify the MDS items that were predictive of costs. We did not make decisions about the inclusion of these items and the values accepted for them unless the decision could be supported by the data analyses. As we continue to perform data analyses to identify the best way to recognize non-therapy ancillary costs, we will take into consideration the suggestions offered during the comment period. We plan to reexamine, using national data, which MDS items are predictive of non-therapy ancillary costs.

3. Medical Review and Fiscal Intermediary Issues

Comment: Many comments suggested that implementation of the refinements should be accompanied by HCFA-sponsored provider training. The reasons given for the additional training request are the expectation that the refinements will require software changes as well as some other operational changes. A few also suggested that clinical staff in particular, needed additional training because the refined RUG–III groups would necessitate changes in assessing, coding and documenting clinical decisions.

Response: Although we are not going forward with the proposed refinements, we do intend to proceed with our plans for provider and fiscal intermediary training, in order to ensure that they have the most current information available on medical review procedures, claims processing requirements, and other aspects of the SNF PPS. We have already made plans for the provision of both ''train-the-trainer'' sessions for the fiscal intermediaries and for other HCFA-sponsored provider training to present updates on all aspects of the SNF PPS. We believe that having a full understanding of the payment and classification systems will help

providers achieve their highest levels of performance.

4. Section U of the Minimum Data Set

Comment: We received a few comments expressing disappointment at our decision not to collect medication data using Section U of the minimum data set (MDS). These commenters suggested that we are losing an opportunity to collect very important information about the medications being offered to Medicare beneficiaries. They point out the importance of this data collection from both quality of care and payment perspectives. We also received a comment applauding our decision not to collect the medication data, which stated that the MDS should be streamlined rather than expanded.

Response: We appreciate the commenters' concerns but, as stated in the proposed rule, we cannot collect the medication data beginning in October 2000, as we had planned. However, we are continuing our evaluation and will take all of the comments into consideration in that process.

B. Update of Payment Rates Under the Prospective Payment System for Skilled Nursing Facilities

1. Federal Prospective Payment System

This final rule sets forth a schedule of Federal prospective payment rates applicable to Medicare Part A SNF services beginning October 1, 2000. The schedule incorporates per diem Federal rates that provide Part A payment for all costs of services furnished to a beneficiary in an SNF during a Medicare-covered stay. Tables 1 and 2 reflect the updated components of the unadjusted Federal rates.

TABLE 1.—UNADJUSTED FEDERAL RATE PER DIEM

[Urban]

Rate component	Nursing—Case-mix	Therapy—Case-mix	Therapy—Non-case mix	Non-case-mix
Per Diem Amount	$114.38	$86.16	$11.35	$58.38

TABLE 2.—UNADJUSTED FEDERAL RATE PER DIEM

[Rural]

Rate component	Nursing—Case-mix	Therapy—Case-mix	Therapy—Non-case mix	Non-case-mix
Per Diem Amount	$109.29	$99.34	$12.13	$59.45

2. Case-Mix Adjustment

As noted earlier in this final rule, we are not proceeding with the implemenation of the RUG refinements discussed in the proposed rule. Accordingly, the payment rates set forth in this final rule reflect the continued use of the 44-group RUG-III classification system discussed in the May 12, 1998 interim final rule (63 FR 26252). The case-mix adjusted payment rates are listed separately for urban and rural SNFs in Tables 3 and 4, with the corresponding case-mix index values.

TABLE 3.—CASE-MIX ADJUSTED FEDERAL RATES AND ASSOCIATED INDICES

RUG IV category	Nursing index	Therapy index	Nursing component	Therapy component	Therapy non-case-mix component	Non-case-mix component	Total rate
RUC	1.30	2.25	$148.69	$193.86	.....	$58.38	$400.93
RUB	0.95	2.25	108.66	193.86	.....	58.38	360.90
RUA	0.78	2.25	89.22	193.86	.....	58.38	341.46
RVC	1.13	1.41	129.25	121.49	.....	58.38	309.12
RVB	1.04	1.41	118.96	121.49	.....	58.38	298.83
RVA	0.81	1.41	92.65	121.49	.....	58.38	272.52
RHC	1.26	0.94	144.12	80.99	.....	58.38	283.49
RHB	1.06	0.94	121.24	80.99	.....	58.38	260.61
RHA	0.87	0.94	99.51	80.99	.....	58.38	238.88
RMC	1.35	0.77	154.41	66.34	.....	58.38	279.13
RMB	1.09	0.77	124.67	66.34	.....	58.38	249.39
RMA	0.96	0.77	109.80	66.34	.....	58.38	234.52
RLB	1.11	0.43	126.96	37.05	.....	58.38	222.39
RLA	0.80	0.43	91.50	37.05	.....	58.38	186.93
SE3	1.70	.....	194.45	.....	$11.35	58.38	264.18
SE2	1.39	.....	158.99	.....	11.35	58.38	228.72
SE1	1.17	.....	133.82	.....	11.35	58.38	203.55
SSC	1.13	.....	129.25	.....	11.35	58.38	198.98
SSB	1.05	.....	120.10	.....	11.35	58.38	189.83
SSA	1.01	.....	115.52	.....	11.35	58.38	185.25
CC2	1.12	.....	128.11	.....	11.35	58.38	197.84
CC1	0.99	.....	113.24	.....	11.35	58.38	182.97
CB2	0.91	.....	104.09	.....	11.35	58.38	173.82

TABLE 3.—CASE-MIX ADJUSTED FEDERAL RATES AND ASSOCIATED INDICES—Continued

RUG IV category	Nursing index	Therapy index	Nursing component	Therapy component	Therapy non-case-mix component	Non-case-mix component	Total rate
CB1	0.84		96.08		11.35	58.38	165.81
CA2	0.83		94.94		11.35	58.38	164.67
CA1	0.75		85.79		11.35	58.38	155.52
IB2	0.69		78.92		11.35	58.38	148.65
IB1	0.67		76.63		11.35	58.38	146.36
IA2	0.57		65.20		11.35	58.38	134.93
IA1	0.53		60.62		11.35	58.38	130.35
BB2	0.68		77.78		11.35	58.38	147.51
BB1	0.65		74.35		11.35	58.38	144.08
BA2	0.56		64.05		11.35	58.38	133.78
BA1	0.48		54.90		11.35	58.38	124.63
PE2	0.79		90.36		11.35	58.38	160.09
PE1	0.77		88.07		11.35	58.38	157.80
PD2	0.72		82.35		11.35	58.38	152.08
PD1	0.70		80.07		11.35	58.38	149.80
PC2	0.65		74.35		11.35	58.38	144.08
PC1	0.64		73.20		11.35	58.38	142.93
PB2	0.51		58.33		11.35	58.38	128.06
PB1	0.50		57.19		11.35	58.38	126.92
PA2	0.49		56.05		11.35	58.38	125.78
PA1	0.46		52.61		11.35	58.38	122.34

TABLE 4.—CASE-MIX ADJUSTED FEDERAL RATES AND ASSOCIATED INDICES

[Rural]

RUG IV category	Nursing index	Therapy index	Nursing component	Therapy component	Therapy non-case-mix component	Non-case-mix component	Total rate
RUC	1.30	2.25	$142.08	$223.52		$59.45	$425.05
RUB	0.95	2.25	103.83	223.52		59.45	386.80
RUA	0.78	2.25	85.25	223.52		59.45	368.22
RVC	1.13	1.41	123.50	140.07		59.45	323.02
RVB	1.04	1.41	113.66	140.07		59.45	313.18
RVA	0.81	1.41	88.52	140.07		59.45	288.04
RHC	1.26	0.94	137.71	93.38		59.45	290.54
RHB	1.06	0.94	115.85	93.38		59.45	268.68
RHA	0.87	0.94	95.08	93.38		59.45	247.91
RMC	1.35	0.77	147.54	76.49		59.45	283.48
RMB	1.09	0.77	119.13	76.49		59.45	255.07
RMA	0.96	0.77	104.92	76.49		59.45	240.86
RLB	1.11	0.43	121.31	42.72		59.45	223.48
RLA	0.80	0.43	87.43	42.72		59.45	189.60
SE3	1.70		185.79		12.13	59.45	257.37
SE2	1.39		151.91		12.13	59.45	223.49
SE1	1.17		127.87		12.13	59.45	199.45
SSC	1.13		123.50		12.13	59.45	195.08
SSB	1.05		114.75		12.13	59.45	186.33
SSA	1.01		110.38		12.13	59.45	181.96
CC2	1.12		122.40		12.13	59.45	193.98
CC1	0.99		108.20		12.13	59.45	179.78
CB2	0.91		99.45		12.13	59.45	171.03
CB1	0.84		91.80		12.13	59.45	163.38
CA2	0.83		90.71		12.13	59.45	162.29
CA1	0.75		81.97		12.13	59.45	153.55
IB2	0.69		75.41		12.13	59.45	146.99
IB1	0.67		73.22		12.13	59.45	144.80
IA2	0.57		62.30		12.13	59.45	133.88
IA1	0.53		57.92		12.13	59.45	129.50
BB2	0.68		74.32		12.13	59.45	145.90
BB1	0.65		71.04		12.13	59.45	142.62
BA2	0.56		61.20		12.13	59.45	132.78
BA1	0.48		52.46		12.13	59.45	124.04
PE2	0.79		86.34		12.13	59.45	157.92
PE1	0.77		84.15		12.13	59.45	155.73
PD2	0.72		78.69		12.13	59.45	150.27
PD1	0.70		76.50		12.13	59.45	148.08

TABLE 4.—CASE-MIX ADJUSTED FEDERAL RATES AND ASSOCIATED INDICES—Continued

[Rural]

RUG IV category	Nursing index	Therapy index	Nursing component	Therapy component	Therapy non-case-mix component	Non-case-mix component	Total rate
PC2	0.65	.....	71.04	.....	12.13	59.45	142.62
PC1	0.64	.....	69.95	.....	12.13	59.45	141.53
PB2	0.51	.....	55.74	.....	12.13	59.45	127.32
PB1	0.50	.....	54.65	.....	12.13	59.45	126.23
PA2	0.49	.....	53.55	.....	12.13	59.45	125.13
PA1	0.46	.....	50.27	.....	12.13	59.45	121.85

C. Wage Index Adjustment to Federal Rates

Section 1888(e)(4)(G)(ii) of the Act requires that we provide for adjustments to the Federal rates to account for differences in area wage levels using an ''appropriate'' wage index as determined by the Secretary. It is our intent to evaluate a wage index based specifically on SNF data once it becomes available. The SNF wage data are currently being collected and evaluated to determine if we can utilize them in the future. If a wage index based on SNF data is developed, we will publish it for comment. However, in the interim, many commenters urged us to incorporate the latest wage data available. We continue to believe that, until a wage index based on SNF wage data is collected and analyzed, the hospital wage index's wage data provide the best available measure of comparable wages that should be paid by SNFs. Since hospitals and SNFs compete in the same labor market area, we believe that the use of this index's wage data results in an appropriate adjustment to the labor portion of SNF costs based on an ''appropriate'' wage index, as required under section 1888(e) of the Act.

The computation of the wage index is similar to past years in that we incorporate the latest data and methodology used to construct the hospital wage index (see the discussion in the May 12, 1998 interim final rule (63 FR 26274)). The wage index adjustment is applied to the labor-related portion of the Federal rate, which is 77.870 percent of the total rate. Tables 5 and 6 below shows the Federal rates by labor-related and non-labor-related components.

TABLE 5.—CASE-MIX ADJUSTED FEDERAL RATES FOR URBAN SNFS BY LABOR AND NON-LABOR COMPONENT

RUGs IV category	Labor-related	Non-labor-related	Total federal rate
RUC	$312.20	$88.73	$400.93
RUB	281.03	79.87	360.90
RUA	265.89	75.57	341.46
RVC	240.71	68.41	309.12
RVB	232.70	66.13	298.83
RVA	212.21	60.31	272.52
RHC	220.75	62.74	283.49
RHB	202.94	57.67	260.61
RHA	186.02	52.86	238.88
RMC	217.36	61.77	279.13
RMB	194.20	55.19	249.39
RMA	182.62	51.90	234.52
RLB	173.18	49.21	222.39
RLA	145.56	41.37	186.93
SE3	205.72	58.46	264.18
SE2	178.10	50.62	228.72
SE1	158.50	45.05	203.55
SSC	154.95	44.03	198.98
SSB	147.82	42.01	189.83
SSA	144.25	41.00	185.25
CC2	154.06	43.78	197.84
CC1	142.48	40.49	182.97
CB2	135.35	38.47	173.82
CB1	129.12	36.69	165.81
CA2	128.23	36.44	164.67
CA1	121.10	34.42	155.52
IB2	115.75	32.90	148.65
IB1	113.97	32.39	146.36
IA2	105.07	29.86	134.93
IA1	101.50	28.85	130.35
BB2	114.87	32.64	147.51
BB1	112.20	31.88	144.08
BA2	104.17	29.61	133.78
BA1	97.05	27.58	124.63
PE2	124.66	35.43	160.09
PE1	122.88	34.92	157.80

TABLE 5.—CASE-MIX ADJUSTED FEDERAL RATES FOR URBAN SNFS BY LABOR AND NON-LABOR COMPONENT—Continued

RUGs IV category	Labor-related	Non-labor-related	Total federal rate
PD2	118.42	33.66	152.08
PD1	116.65	33.15	149.80
PC2	112.20	31.88	144.08
PC1	111.30	31.63	142.93
PB2	99.72	28.34	128.06
PB1	98.83	28.09	126.92
PA2	97.94	27.84	125.78
PA1	95.27	27.07	122.34

TABLE 6.—CASE-MIX ADJUSTED FEDERAL RATES FOR RURAL SNFS BY LABOR AND NON-LABOR COMPONENT

RUGs IV category	Labor-related	Non-labor-related	Total federal rate
RUC	$330.99	$94.06	$425.05
RUB	301.20	85.60	386.80
RUA	286.73	81.49	368.22
RVC	251.54	71.48	323.02
RVB	243.87	69.31	313.18
RVA	224.30	63.74	288.04
RHC	226.24	64.30	290.54
RHB	209.22	59.46	268.68
RHA	193.05	54.86	247.91
RMC	220.75	62.73	283.48
RMB	198.62	56.45	255.07
RMA	187.56	53.30	240.86
RLB	174.02	49.46	223.48
RLA	147.64	41.96	189.60
SE3	200.41	56.96	257.37
SE2	174.03	49.46	223.49
SE1	155.31	44.14	199.45
SSC	151.91	43.17	195.08
SSB	145.10	41.23	186.33
SSA	141.69	40.27	181.96
CC2	151.05	42.93	193.98
CC1	139.99	39.79	179.78
CB2	133.18	37.85	171.03
CB1	127.22	36.16	163.38
CA2	126.38	35.91	162.29
CA1	119.57	33.98	153.55
IB2	114.46	32.53	146.99
IB1	112.76	32.04	144.80
IA2	104.25	29.63	133.88
IA1	100.84	28.66	129.50
BB2	113.61	32.29	145.90
BB1	111.06	31.56	142.62
BA2	103.40	29.38	132.78
BA1	96.59	27.45	124.04
PE2	122.97	34.95	157.92
PE1	121.27	34.46	155.73
PD2	117.02	33.25	150.27
PD1	115.31	32.77	148.08
PC2	111.06	31.56	142.62
PC1	110.21	31.32	141.53
PB2	99.14	28.18	127.32
PB1	98.30	27.93	126.23
PA2	97.44	27.69	125.13
PA1	94.88	26.97	121.85

As discussed above and in the proposed rule, until an appropriate wage index based specifically on SNF data is available, we will use the latest available hospital wage index data in making annual updates to the payment rates. In making these annual updates, section 1888(e)(4)(G)(ii) of the Act requires that the application of this wage index be made in a manner that does not result in aggregate payments that are greater or less than would otherwise be made in the absence of the wage adjustment. In this third PPS year (Federal rates effective October 1, 2000), we are updating the wage index applicable to SNF payments using the most recent hospital wage data and applying an adjustment to fulfill the budget neutrality requirement. This requirement will be met by multiplying